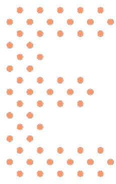

EveryMind

Request to Correct Personal Health Information From the Clinical Record Compiled at EveryMind

Under the Personal Health Information Protection Act, 2004

Child/Youth Information

Last name: ______________________________

First name: ______________________________

Date of Birth*: ______________________________

Address: ______________________________ Apt./Unit #: _______

City: ____________________ Province: ____________ Postal Code: ____________

Phone (home): ____________________ Phone (cell): ____________________

** If child is 12 years of age or older, child/youth must authorize request by signing below*

*Parent/Legal Guardian (substitute decision-maker) Information***

Last name: ______________________________

First name: ______________________________

Address: ______________________________ Apt./Unit #: _______

City: ____________________ Province: ____________ Postal Code: ____________

Phone (home): ____________________ Phone (cell): ____________________

*** You may be asked to provide documentation that demonstrates that you are the authorized substitute decision-maker*

Correction requested *(please describe information to be corrected, reasons information is inaccurate or incomplete and provide corrected information)*

____

____

____

Child/Youth Signature: ____________________ Date: ____________

Parent/Guardian Signature: ____________________ Date: ____________

Please complete this form and fax to Clinical Records 905-696-0350 **OR**
mail to EveryMind Clinical Records, 85A Aventura Court, Mississauga ON L5T 2Y6
For more information call Clinical Records 905-795-3500 ext. 2323

For office use only:

File #: ____________

Date request received: ____________________ Date manager notified: ____________________

Outcome of request, including resolution date: ______________________________

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